## THIRD PARTY COLLECTION PROGRAM - INSURANCE INFORMATION

(Read Privacy Act Statement on back before completing this form.)

REPORT CONTROL SYMBOL

Form Approved OMB No. 0704-0323 Expires Jun 30, 2000

The public reporting burden for this collection of information is estimated to average 2.5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0704-0323), 1215 Jefferson Davis Highway. Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THIS ADDRESS. RETURN COMPLETED FORM TO REQUESTING MILITARY TREATMENT FACILITY.

<b>SECTION I - PATIENT INF</b>	ORMA	ATION										
1. NAME (Last, First, Middle Initial)						2. PATIENT SSN		3. DATE OF BIRTH (YYYYMMDD)				
4. ADDRESS						5. TELEPHONE NUMBER						
a. STREET (Include apartment number)						a. HOME b. OFFICE						
						( )						
b. CITY		c. STATE		d. ZIP COD	E	6. SPONSOR'S BRANCH OF SERVICE						
7. FAMILY MEMBER PREFIX/SPONSOR SSN						8. RELATION OF PATIENT TO INSURED						
9. IS PATIENT'S CONDITION RELATED TO AN ACCIDENT (X one)						YES (Complete a e.)	NO (Complete d. and e.)					
a. TYPE OF ACCIDENT (X one) (Con	information requirements			b. DA	TE OF ACCIDENT	d. DATE OF ADMISSION/ e. HOUR						
as stated in DoDI 6010.15)						YYYMMDD)		VISIT (YYYYMMDD)				
AUTO ACCIDENT	OTHER	THER (Type)										
SECTION II - INSURANCE	CARI	RIFRI	NEORI	ΜΑΤΙΩΝ /	Comple	ete for all Health Incur	ance nolicie	e and	employers )			
SECTION II - INSCRAIGE	- OAIN	\\I_\\	I O I ( )	IIATION (	Compi	ete for all ricaliti filsul	ance policie	s and t	employers.)			
10. EMPLOYER OF POLICY HO												
a. NAME					b. TELEPHONE NUMBER							
									( )			
c. ADDRESS												
(1) STREET (Include apartment or suite number)					(2) CITY		(3) STATE (4) ZIP CODE			DDE		
11. PRIMARY MEDICAL INSUR	ANCE P	OLICY										
a. INSURANCE TYPE (X one)		ā			=							
GROUP HEALTH PLAN			INDIVIDUAL			SUPPLEMENTAL MEDICARE A			SUPPLEMENTAL MEDICARE B			
b. NAME OF POLICY HOLDER			c. SSN OF POLICY			d. GROUP POLICY NUMBER			e. INDIVIDUAL POLICY NUMBER			
(Last, First, Middle Initial) HOLDER												
f. INSURANCE COMPANY						g. FAMILY MEMBERS COVERED BY THIS POLICY						
(1) NAME		(2) TELEPHONE NUMBER			(1) NAME			(2) DATE OF (3)				
		( )			(Last, First, Middle Initial)		ial)	BIRTH (YYYYMMDD) SSN			SSN	
(3) STREET ADDRESS (Include apar	tment or s	uite numl	ber)									
CITY		STATE	ZIP C	ODE								
12. OTHER MEDICAL INSURAN	ICE POL	LICIES (	Use additi	ional pages as	s necess	sary)						
a. INSURANCE TYPE (X one)	i					1			1			
			INDIVIDU			SUPPLEMENTAL MEDICARE A		e. INDIVIDUAL POLICY NUMBER				
b. NAME OF POLICY HOLDER (Last, First, Middle Initial)			c. SSN OF POLICY HOLDER			d. GROUP POLICY NUMBER			DIVIDUAL POI	LICY NUME	BER	
(Last, 1 list, Madic Initial)			ПОЕВ	-11								
( INCURANCE COMPANY						****						
f. INSURANCE COMPANY					g. FAMILY MEMBERS COVERED BY THIS POLICY							
(1) NAME		(2) TELEPHONE NUMBER			(1) NAME			(2) DATE OF (3) BIRTH (YYYYMMDD) SSN				
						(Last, First, Middle Initial)			(טטואוואדדדד)		OON	
(2) STREET ADDRESS (In-dist)	rtma o /- t -	aulta :-::	, b o r l									
(3) STREET ADDRESS (Include apa	runent of s	suite num	iber)									
CITY		STATE	ZIP C	ODE	-							
J		VIAIE	215 0		<u> </u>							

## **SECTION III - PRIVACY ACT STATEMENT** AUTHORITY: Title 10 USC, Sec. 1095; EO 9397. PRINCIPAL PURPOSE(S): Information will be used to collect from private insurers for medical care provided to military dependents and retirees. Such monetary benefits accruing to the Military Treatment Facility will be used to enhance health care delivery in the Military Treatment Facility. Information will also be used by Military Treatment Facility staff and TRICARE Support Office Contractors to determine eligibility for care, deductibles, and co-shares. ROUTINE USE(S): The information on this form will be released to your insurance company, to staff of facilities of the uniformed services, and to health care providers to support claims for reimbursement. DISCLOSURE: Voluntary; however, failure to provide complete and accurate information may result in disqualification for health care services from facilities of the uniformed services. **SECTION IV - RELEASE AND ASSIGNMENT** I acknowledge that portions of my medical records necessary to support claims for reimbursement for the cost of care rendered may be released to my insurance carriers. I acknowledge that the authority to bill third party payers has been conveyed to the medical facility within the Department of Defense by Title 10 U.S. Code, Section 1095, and that no personal entitlement to reimbursement or payment has been granted to me by virtue of this act. I hereby acknowledge that the proceeds of any and all benefits shall be paid directly to the facility of the Uniformed Service for hospitalization or outpatient services provided me and/or my family member. **SECTION V - CERTIFICATIONS** I certify that the information on this form is true and accurate to the best of my knowledge. 13. PATIENT OR ADULT FAMILY MEMBER/SPONSOR a. SIGNATURE b. DATE SIGNED (YYYYMMDD) 14. CLERK a. SIGNATURE b. DATE SIGNED (YYYYMMDD) **SECTION VI - REGISTRATION VERIFICATION** NOTE: Verification of insurance coverage shall be made upon the occasion of each admission or outpatient visit to the Military Treatment Facility. Any time information on this form is changed a new signature must be obtained. Annually, on the first visit after twelve months have passed since the patient's signature was first obtained, a new form must be completed and signed. I certify that the information on this form has been verified on the date(s) specified below, and that all information is true and accurate to the best of my knowledge. 15. FIRST VERIFICATION a. SIGNATURE b. DATE SIGNED (YYYYMMDD) 16. SECOND VERIFICATION

b. DATE SIGNED (YYYYMMDD)

b. DATE SIGNED (YYYYMMDD)

## DD FORM 2569 (BACK), JUL 1997

a. SIGNATURE

a. SIGNATURE

17. THIRD VERIFICATION